Texas Department of Health
Communicable Disease Record

Client #:_____

Name:_____ Date of Birth:_____ Address:_____

City: _____ Disease:_____ Physician's Name:_____

Date of Onset:_____ Duration of Illness:_____ days

Is patient immunocompromised (if yes, explain):_____

Symptoms:

~ Fever (if yes, highest____ EF) ~ Nausea ~ Vomiting ~ Headache ~ Cramping

~ Diarrhea: (Average Number Stools per Day: _____)

Is the diarrhea: ~ Watery ~ Mucoid ~ Bloody

~ Other; describe: _____

Date of Physician Visit:_____ Referral made by:_____ Date:_____

Names (and client #'s) of Associated Cases (if any):_____

_____

Travel History (during incubation period):_____

_____

HOUSEHOLD AND OTHER CASE CONTACTS

Name and Relationship to case	Age	Sex	Race	Address	Occupation	Symptoms (if any)	Date of Onset

(Are any of the above contacts: food handlers, patient care providers, day-care center (DCC) related, i.e., child in DCC, parent of DCC child, a DCC employee?) If yes, give details:_____

_____

LABORATORY RESULTS

Name	Date	Type			Result	
		Stool	Blood	Other	Organism Isolated	Serologic Titer
Patient:						
Contacts:						

PROBABLE SOURCE OF INFECTION: (T If applicable)

~ Person to Person
~ Family contact name:
~ Day-care center contact name:
~ Other:
~ Mosquito-borne:
~ Tick-borne:
~ Animal contact:
~ Blood products; needle exposure, etc.:
~ Hobby (hunting, fishing, etc.); explain:
~ Chemical exposure(if yes, explain):
~ Food
~ Water Specify in the below table the suspect food, water, or milk consumed during the incubation period::
~ Milk A

Type	Source	Date
(e.g.-milk, food, water)	(e.g.-specific store, restaurant, dairy, etc.)	(purchase and/or consumption)

Other; explain:

CONTROL MEASURES FOR PATIENT, FAMILY, AND CONTACTS: (T if appropriate measures taken)

Education:
~ Disease process (symptoms, incubation period, method of transmission, period of communicability)
~ Hand washing
~ Food handling
~ Other

~ Prior immunizations for this disease:
~ Immunizations recommended for this disease:
~ Antibiotic prophylaxis recommended (specify):
~ Immune globulin recommended:
~ Appropriate health department division notified (e.g., Immunization; Environmental Health; Epidemiology, etc.)
~ Mosquito control district notified:
~ Referral to physician;
~ Follow-up of contacts;
~ Cultures taken (what and where):
~ Other:

~ Reportable disease
~ Surveillance form completed; date mailed:

Signature/Title of Investigator: Date Investigated: